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Elizabeth P. Hall
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May 27, 2010

Commissioner David Morales
Division of Health Care Finance and Policy
2 Boylston Street, 5th Floor
Boston, MA 02116

Re: Proposed Regulations 114.5 CMR 21.00: Health Care Claims Data Submission and 114.5 CMR 22.00: Health Care Claims Data Release

Dear Commissioner Morales,

WellPoint, Inc. (WellPoint) appreciates this opportunity to respond to *Regulations 114.5 CMR 21.00: Health Care Claims Data Submission and 114.5 CMR 22.00: Health Care Claims Data Release.* WellPoint recognizes the efforts of the Massachusetts Division of Health Care Finance and Policy (Division) to establish the guidelines for the creation of this statewide all-payer claims database (APCD) in accordance with *Mass. Gen. Laws Ann. 118G §6* (Health Care Finance and Policy) and we appreciate the opportunity to comment on the proposed APCD regulations.

WellPoint is the largest publicly traded commercial health benefits company in terms of membership in the United States with 33.8 million medical members at March 31. WellPoint is an independent licensee of the Blue Cross Blue Shield Association and serves its members as the Blue Cross licensee for California; the Blue Cross and Blue Shield licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as Blue Cross Blue Shield in 10 New York City metropolitan counties and as Blue Cross or Blue Cross Blue Shield in selected upstate counties only), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.), and Wisconsin; and UniCare Life and Health nationwide. UniCare provides administrative services such as claims processing, customer service and utilization management for the Commonwealth's Group Insurance Commission (GIC).

While we are appreciative of the efforts by the Division to establish guidelines for the creation of the APCD, WellPoint is concerned by a number of issues raised by the regulations. We believe that our experience can be beneficial to the Division in its development of the APCD. What follows are details of our concerns.

1. Applicability of Regulations

It is our assumption that the regulations are intended to apply only to data for residents of the state of Massachusetts covered under policies issued in this state (e.g. information for individuals

insured under a group insurance plan issued in another state would not be included in the reporting requirements); however, the regulations are unclear on this point. Our assumption is based in part on our belief that that the Division does not have the jurisdiction to require payers to submit private health care plan information (premium information, actuarial assumptions used in rate development, summary plan designs, medical loss ratio information, reserve/surplus information, and information on provider payment levels and methodologies) for policies not issued in the state. We also recognize that including health care data for individuals insured under plans issued in other states greatly increases the administrative burden for reporting, both for payers and for the Division. The Division should also recognize that requiring payers to submit data for residents of Massachusetts covered by out-of-state ASO employers will require payers to obtain permission from their ASO clients to submit this data. For all of these reasons, we recommend that the Division add language to the regulation specifying that payers must only submit data for residents of the state of Massachusetts covered by policies issued in the state of Massachusetts.

A related concern is the requirement set forth in section 21.03(1) that requires payers to submit additional information as necessary to ensure that the Division has complete and accurate information. We appreciate the Division's desire to provide accurate information; however we are concerned that the current wording could lead to inconsistent reporting and appears to provide the Division with the authority to require payers to submit any data requested by the Division. Without a clear definition of what the Division considers "complete and accurate information" different individuals reviewing information submitted by different payers may draw different conclusions about whether or not additional information is required. This not only leads to inconsistent reporting, it also adds to the administrative costs associated with executing this reporting requirement and could add significantly to the amount of time required to complete the reporting process. WellPoint suggests that the Division clarify what it means by "complete and accurate information." It is also important for the Division to recognize the role of providers with respect to the completeness and accuracy of the data submitted to the Division by payers. The data submitted by payers will only be as complete and accurate as that it receives from providers.

Lastly, we ask that the Division work with other state agencies to clearly outline what current data submissions payers will be relieved of when these regulations go into effect and to work with them to repeal existing data submission as appropriate.

2. Proposed Timeline

As drafted, the data submission regulations require payers to submit information to the Division beginning on or before October 15, 2010, with subsequent submissions occurring on the 15th of each month. To maximize the benefits of the APCD and to ensure a smooth implementation of the new reporting requirements, we recommend that the Division provide a longer time period in which claims submission procedures are tested to make sure that the system functions properly without significant errors. We note that neither proposed regulation acknowledges the need for testing of the system and we are concerned that failure to follow proper protocol in implementing this new requirement could pose a threat to consumers (in that inaccurate data submissions are likely to yield inaccurate findings), carriers, and the integrity of the claims database itself.

We are also concerned that these new reporting requirements come at a time when payers are struggling to provide the necessary personnel and financial resources to meet previously issued mandates, such as implementation of HIPAA 5010 and ICD-10, and prepare for upcoming administrative simplification mandates while controlling our administrative expenses and meeting

newly established minimum loss ratio requirements. Although WellPoint's subsidiary UniCare has been submitting data to the Division through the Health Care Quality and Cost Council (HCQCC) data feed, the proposed regulations represent a significant expansion in the information required (denied claims, provider/pharmacy/product files, etc.). Furthermore, the proposed schedule for data submission, beginning in October 2010, does not provide payers with adequate time to program, execute, and test the data extracts required for data submission. To ensure the success of this initiative it is imperative that payers be given adequate time to implement these highly technical and complex reporting requirements without jeopardizing our ability to comply with previously established mandates.

We respectfully urge the Division not to require the first data submission under these new regulations until at least six months after publication of the final rule. Should there be an extraterritorial application of the regulations such that payers will be required to submit data for Massachusetts residents who are members of policies issued in another state, payers will need even more time, at a minimum nine months, to make the necessary system changes to provide this data. This time is necessary for payers to reallocate resources and manage existing projects and to ensure that their data submissions comply with the Division's requests.

Similarly, it is also important that the Division develop and follow a schedule for making any changes to data elements or file format required for submission, and should notify plans no less than six months in advance of any required changes. Any change to data elements or formatting of information requires system changes and creates an incremental cost. Managing the number of times throughout the year that such changes can be made and allowing adequate time for payers to make and test the necessary system adjustments to support the change will ensure the ongoing integrity of the data and help to contain costs associated with these reporting requirements.

We also respectfully request that the deadline for submitting monthly files be pushed to later in the month. The proposed requirements that files be submitted on by the 15th day of the following month creates a logistical issue for data warehouses in that prior month's data may not be available until at least twelve days into the succeeding month, and additional time is then needed to create, test, validate and submit the file

Lastly, it is important to note that APCD file submissions are generated from warehouses that store member claims data from the claim system. Payers are continually closing/consolidating systems and warehouses in an effort to be more efficient and reduce administrative costs. We recommend adding a provision that recognizes this business reality and allows payers appropriate flexibility in these situations.

3. Uniform Claims Reporting Procedures

As an increasing number of states begin to pursue initiatives requiring the collection of claims data, the importance of uniformity cannot be overstated. Maine, Minnesota, New Hampshire, Tennessee and Vermont have all established health claims reporting requirements, which rely on the same set of standards for both the collection and submission of claims data. The reporting procedures proposed in Massachusetts conflict with these standards. For example, proposed fields MC079 through MC091 are also in use in Tennessee, though not all of the data required in these fields are the same as is being required by Massachusetts. These types of difference in the requested data files could limit the use of the claims data, while also increasing costs as payers will be required to adopt Massachusetts state-specific technical requirements.

A uniform data collection approach also serves to minimize the administrative costs associated with the creation of state APCDs. The procedures and programming required to comply with state-specific claims reporting requirements can be very costly and technical – requiring many hours of work and unnecessarily increasing the administrative costs associated with providing health insurance coverage. Several organizations, including the National Association of Health Data Organizations (NAHDO), the regional All Payer Healthcare Information Council (RAPHIC) and America's Health Insurance Plans (AHIP), are engaged in a national standardization effort.

It is critical that any APCDs adopt nationally recognized reporting standards to ensure interoperability among similar databases and to reduce the administrative burden to payers of submitting this data. The Division should ensure that the required data files in Massachusetts comply with the standards in use in other states and being developed by the organizations noted above. This would be consistent with other state data collection projects and is supported by the APCD's enabling statute.

4. Data Security and Protection of Private, Proprietary and Confidential Data

The proposed regulations do not do enough to safeguard proprietary and confidential payer information. WellPoint respectfully asks that the Division include much stronger data and privacy protections in the final regulations. More specifically, language should be added specifying that:

- Data submitters will not be liable for inappropriate release of proprietary or confidential data or data security breaches made by the Division or any third party with whom the Division contracts in connection with the activities of the APCD;
- The Commissioner will be responsible for ensuring data integrity and security;
- The Commissioner shall enter into *Data Use and Reciprocal Support Agreements* (DURSA) with data submitters. Such agreements should clearly identify each party's responsibilities and financial liability should a security breach occur;
- Patient privacy will be protected as required by state and federal laws, including HIPAA;
- The following information submitted by payers will be regarded as confidential and will not be released in either the public use or restricted use data files:
    - Data as it relates to the data submitter's corporate plan or reorganization;
    - Data that contains either a trade secret or contract information that would, if revealed, substantially and adversely affect the ability of the data submitter, its affiliated interests or the other persons or entities with which the data submitter is engaging in a joint venture or commercial action to compete with other entities offering or proposing to offer the same goods and services in the same market;
    - Data that would, if revealed, substantially and adversely affect the ability of the data submitter or its affiliated interest to obtain financing on reasonable terms in competition with others seeking similar types of capital;
    - Data that could lawfully be concealed under applicable laws governing financial transactions; and

- Data that is restricted under a confidentiality agreement between the data submitter and its business partner(s).

In addition, we are concerned that the proposed list of data elements requires the submission of data that goes beyond the minimum amount necessary for the state to create and maintain an APCD. *Mass. Gen. Laws Ann. 118G §6* requires "the Division shall, before adopting regulations under this section, consult with other agencies of the commonwealth and the federal government, affected providers, and affected payers, as applicable, to ensure that the reporting requirements imposed under the regulations are not duplicative or excessive." Furthermore, the same statute also requires that "data collection and analytical methodologies shall be used that meet accepted standards of validity and reliability." We therefore request that a thorough review of the data elements be conducted to safeguard the personal privacy and proprietary nature of the data and to require reporting of only those elements that are needed to achieve the purposes outlined in the statute.

5. Penalties

The penalties section in 114.5 CMR 21.04 is unclear. It states that if any payer fails to submit required data to the Division on a timely basis, or fails to correct submissions rejected because of errors, the Division or its designee shall provide written notice to the payer. If the payer fails to provide the required information within two weeks following receipt of said written notice, the Division will take all necessary steps to enforce this provision to the fullest extent of the law. The proposed regulations do not provide any guidance in terms of the weekly penalty amount and the annual maximum. Further clarification is needed to explain what those financial penalties will be and how those funds will be used. In addition, we request that language be adjusted to exempt payers from a penalty when corrected information cannot be provided within the two-week window and the payer is making a good faith effort to work with the Division and provide the corrected information as quickly as possible.

6. Refinement of Required Data Elements List

The data elements outlined in the proposed rule include a number of data points that are not collected by health carriers or are not submitted by health care providers as part of the current claims submission and payment processes. Requiring payers to capture and store additional data that does not provide a business benefit is costly as many payers will have to modify numerous core IT systems and warehouses. In addition, requiring claims information unique to Massachusetts conflicts with the requirement for national standards and uniform operating rules regarding electronic claims submissions outlined in the recently passed Patient Protection and Affordable Care Act (PPACA). We suggest that implementation of these new reporting requirements will be enhanced, and the transition eased, if the following data fields are designated as optional fields for reporting: 1) race, 2) ethnicity, 3) designated primary care physician (PCP), 4) PCP ID, 5) drug information, 6) diagnosis related group (DRG), 7) rendering provider specialty, and 8) student status (given required changes to dependent coverage under federal health reform). We understand that the technical manual advises data suppliers to explain any missing data elements (such as those noted above); however, greater clarity around the treatment of optional data elements would be helpful. Furthermore, we also respectfully suggest that claims data be required only to the extent they are required by national standards (ANSI 4010 837I, 837P, 5010, etc.) and that thresholds not be set for non-required, situational data.

WellPoint would like to thank the Division for arranging for a discussion between WellPoint and Division staff to discuss technical concerns regarding the required data submission. Pursuant to that discussion, we respectfully ask that more detail be added to the data submission specifications to clarify reporting thresholds, the handling of null values for data that is not collected, etc. so that the limited resources that are available to pull and submit the required data can be used most efficiently.

7. Data Governance and Release

Given the complexity and sensitivity of health care data, it is imperative that data submitters be involved in the governance of the data, including its use and release. The draft regulations do not go far enough to protect the data from inappropriate use or release – both of which could ultimately harm consumers.

For example, in section 22.02, the definition of claims data ("...and all other data submitted by payers and other health care claims processors to the Division without restriction.") is overly broad and likely permits the release of confidential information. We suggest that this language be amended such that the Division may only release the data specified in the data release file specifications (for public and restricted use).

At the very least it is imperative that the membership of the Data Release Committee consist of at least one payer representative who possesses a certain level of expertise regarding the data submitted to the Division. A payer representative is likely to be in the best position to explain whether the intended use of the data is appropriate and why certain confidential information should or should not be released. We respectfully request that the Division amend the composition of the Committee to include at least one payer representative and require that the Commissioner be required to consult with the Data Release Committee on all applications for data.

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WellPoint appreciates this opportunity to offer our comments on these draft regulations and we look forward to working with the Division on this issue. Should you have any questions or wish to discuss our comments further, please contact Ashley Walter-Dumm at (312)485-9609 or Ashley.Walter-Dumm@wellpoint.com.

Sincerely,

Elizabeth P. Hall
Vice President, Public Policy